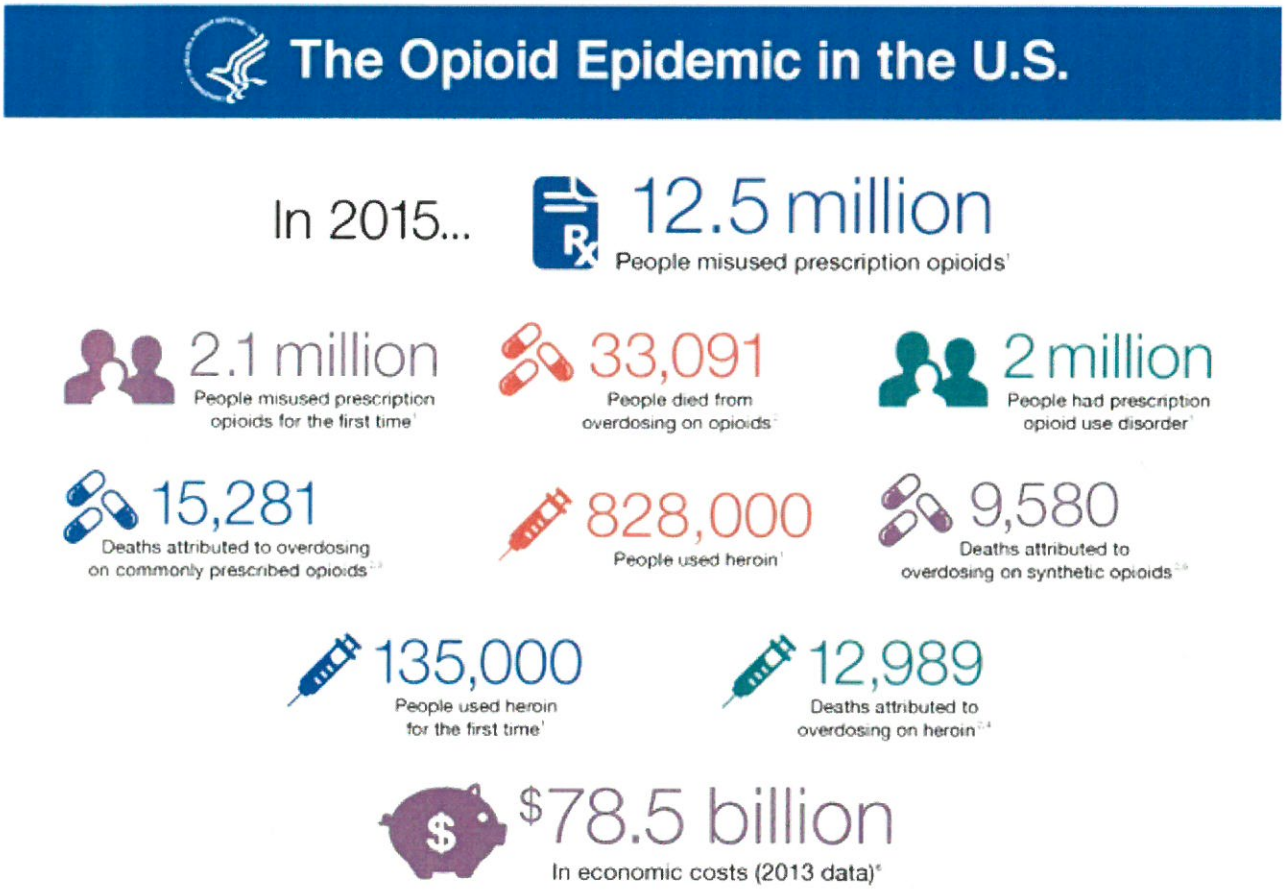
First Patient Story

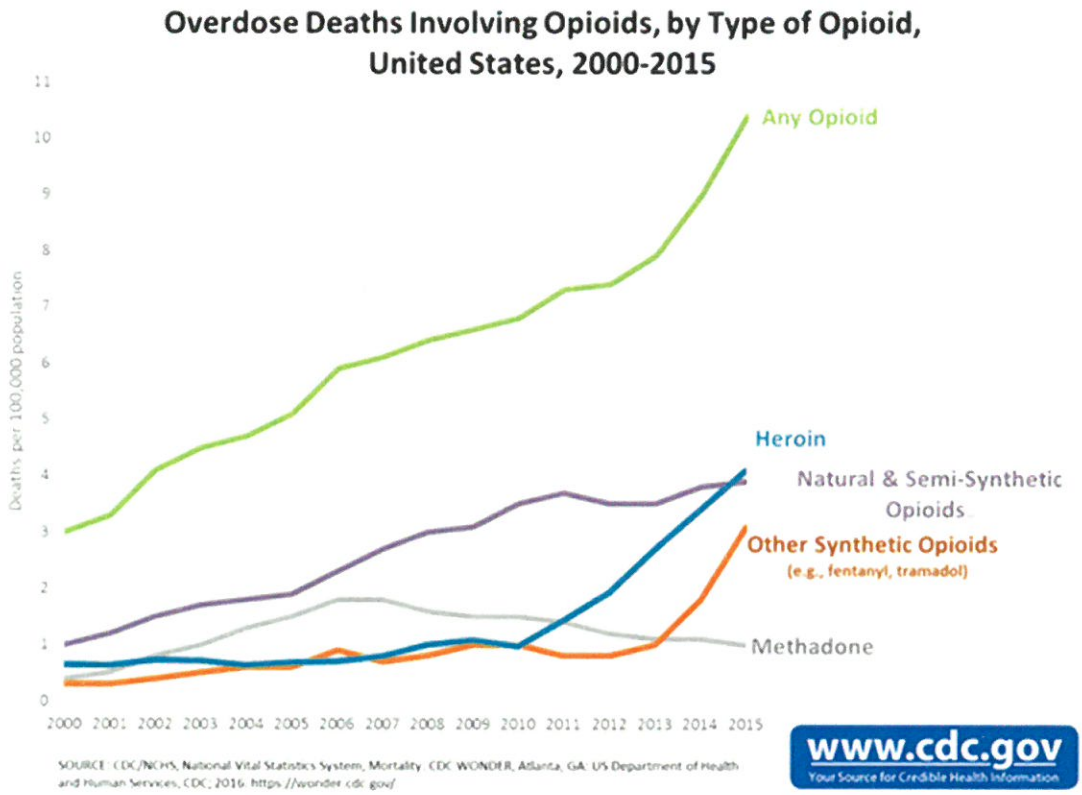
- (Story) If my patient has a kidney stone …
- Then later in the month he breaks his leg …
- Prescriber's Letter; October 2017; Vol: 24
- Insurance company restrictions on opioid prescribing for short term use interfere with quality care.

Facts and Figures

- CDC
- Opioid deaths are increasing and at crisis level.



- Doctors are responding to this messaging



- Prescriptions have leveled off from 2010 to 2015
- Heroin and illegally imported and distributed synthetic opioids are becoming more available

Has our caution gone too far?

- (Story) When I started medicine folks were left after surgery without pain control, people were in severe pain. Now this would-be malpractice and this is good. We need to treat real pain with effective medications.
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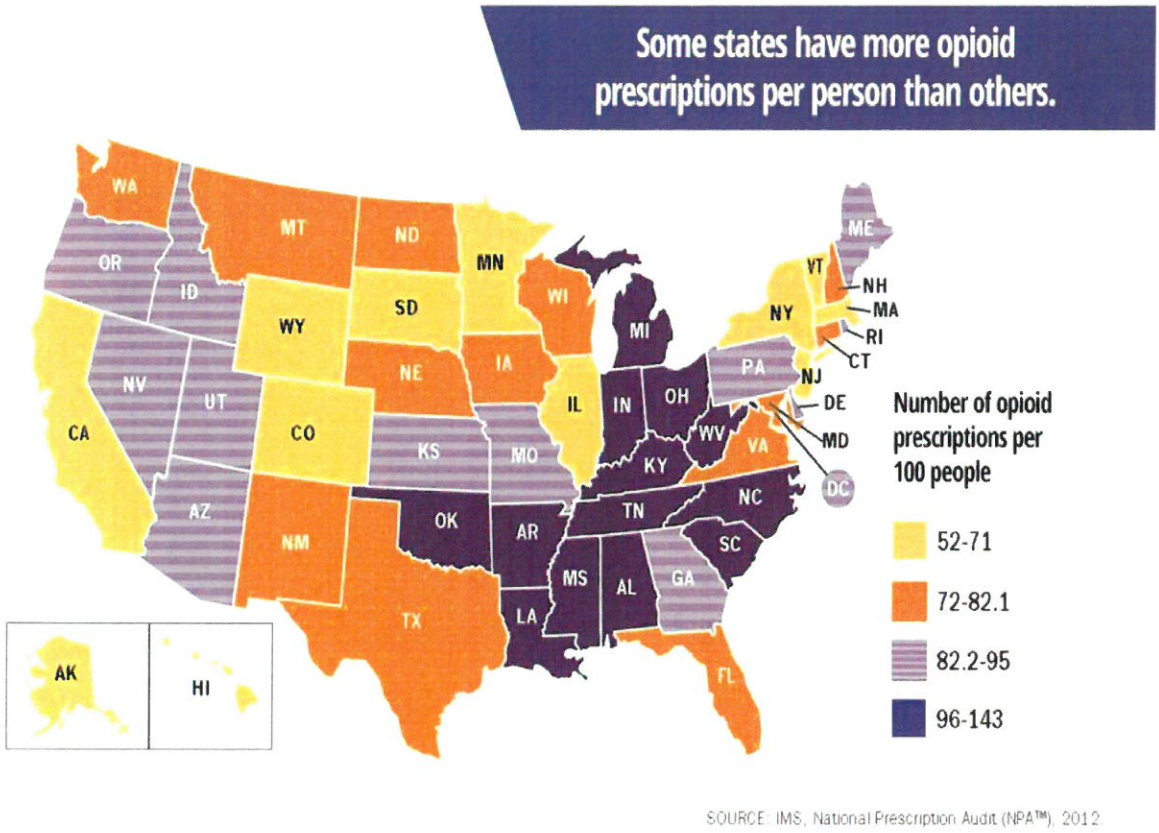
- 70-year-old with significant arthritic changes. Tylenol is not effective. They have stage three kidney failure and hypertension, so the whole NSAID class of medications (ibuprofen (Motrin), Naproxen (Aleve) are too dangerous
- Tramadol (Schedule IV) is safer and Hydrocodone (Schedule II) is safer yet.
- Tradeoff between addiction potential and ability to walk.



SOURCE: IMS, National Prescription Audit (NPA™), 2012

Student Education

- We want our students to be excellent physicians. And part of being an excellent physician is using your tools appropriately. When pain is the problem we try to teach our students to use their many tools. We do IPE presentations in the first and 2nd year on using Physical therapy, Osteopathic Manipulation as well as safe medication prescribing to treat the disability that can come from chronic, debilitating pain.
- We educate on addiction and appropriate use in Pharmacology as we teach them about the classes of medications. And on different medications for diverse types of pain – Neuropathic pain, Muscle spasm pain, central pain, inflammatory pain, etc.
- We teach about addiction and addiction treatment in behavioral medicine and psychiatry as an integrated part of our teaching to develop excellent physicians. Because improving function is vital to our patient's wellbeing. And addiction is not good for our patients.
- In third and fourth year, we pair our students with physicians, who provide diverse viewpoints on pain management and opioid use. Illustrating the many ways to improve pain in our patients.
- During the psychiatry block, there is a required online module on safe prescribing of opioids.

Real, non-cancer pain exists and should be treated.

- Chronic, non-cancer pain is real. A component of this pain, from failed, non-surgical back problems, complex regional pain syndrome, among many others. I hope that none of you will ever have to know what severe, non-cancer pain is like. But if you do, wouldn't you want a physician who can use all the available tools to help you function the best way that you can.
- At times, opioids are the only way to help a debilitated person take care of their children or go to the grocery store.

DIRE Score: Patient Selection for Chronic Opioid Analgesia

For each factor, rate the patient's score from 1-3 based on the explanations in the right-hand column

SCORE	FACTOR	EXPLANATION
	DIAGNOSIS	1 = Benign chronic condition with minimal objective findings or no definite medical diagnosis. Examples: fibromyalgia, migraine headaches, non-specific back pain. 2 = Slowly progressive condition concordant with moderate pain, or fixed condition with moderate objective findings. Examples: failed back surgery syndrome, back pain with moderate degenerative changes, neuropathic pain. 3 = Advanced condition concordant with severe pain with objective findings. Examples: severe ischemic vascular disease, advanced neuropathy, severe spinal stenosis.
	INTRACTABILITY	1 = Few therapies have been tried and the patient takes a passive role in his/her pain management process. 2 = Most customary treatments have been tried but the patient is not fully engaged in the pain management process, or barriers prevent (insurance, transportation, medical illness). 3 = Patient fully engaged in a spectrum of appropriate treatments but with inadequate response.
	RISK	(**R** = Total of **P**+**C**+**R**+**S** below)
	Psychological	1 = Serious personality dysfunction or mental illness interfering with care. Example: personality disorder, severe affective disorder, significant personality issues. 2 = Personality or mental health interferes moderately. Example: depression or anxiety disorder. 3 = Good communication with clinic. No significant personality dysfunction or mental illness.
	Chemical Health	1 = Active or very recent use of illicit drugs, excessive alcohol, or prescription drug abuse. 2 = Chemical coper (uses medications to cope with stress) or history of chemical dependence (CD) in remission. 3 = No CD history. Not drug-focused or chemically reliant.
	Reliability	1 = History of numerous problems: medication misuse, missed appointments, rarely follows through. 2 = Occasional difficulties with compliance, but generally reliable. 3 = Highly reliable patient with meds, appointments & treatment.
	Social Support	1 = Life in chaos. Little family support and few close relationships. Loss of most normal life roles. 2 = Reduction in some relationships and life roles. 3 = Supportive family/close relationships. Involved in work or school and no social isolation.
	EFFICACY SCORE	1 = Poor function or minimal pain relief despite moderate to high doses. 2 = Moderate benefit with function improved in a number of ways (or insufficient info – hasn't tried opioid yet or very low doses or too short of a trial). 3 = Good improvement in pain and function and quality of life with stable doses over time.

Total score = D + I + R + E _____

Score 7-13: Not a suitable candidate for long-term opioid analgesia

Score 14-21: May be a good candidate for long-term opioid analgesia

NOTES

A DIRE Score of ≤13 indicates that the patient may not be suited to long-term opioid pain management.

Belgrade, M. J., Schamber, C. D., & Lindgren, B. R. (2006). The DIRE Score: Predicting Outcomes of Opioid Prescribing for Chronic Pain. The Journal of Pain, 7(9), 671–681. https://doi.org/10.1016/j.jpain.2006.03.001